Medical History **Welcome To Our Office**

We will be happy to help you fill out this form, ask for assistance.

Today's Date: _____ Cell Phone: _____

Home Phone: _____

Work Phone: _____

Title: (circle) Mr. Mrs. Ms. Dr.

Name: _____ Preferred name: _____

First *Middle* *Last*

Date of Birth: _____ /_____ /_____

Social Security Number: _____ Drivers License #: _____ State: _____

Address: _____ City: _____ ST: _____ Zip: _____

Email Address_____ Male: _____ Female: _____

Preferred Methods of contact: (circle all approved) Phone Text Email Mail

How did you hear about us: _____

Occupation/Grade: _____ Marital Status: _____

Race: _____ Ethnicity: (circle) Hispanic/Latino – Not Hispanic/Latino

Primary Insured**:** _____

Name *Social Security Number* *Date of Birth*

Vision Insurance**:** _____ Vision Insurance ID #: _____

Medical Insurance: _____ Medical Insurance ID #: _____

Medical Information Update:

Date of Last Vision Exam: _____ /_____ /_____ Previous Eye Doctor: _____

Date of Last Medical Exam: _____ /_____ /_____ Doctor: _____

Weight: _____ Height: _____ Are you Pregnant and / or nursing: YES / NO

Reason for Visit: _____

Do you wear Glasses: YES / NO

Do you wear Contact Lenses: YES / NO Are they Comfortable: YES / NO

Brand: _____ RX Right eye: _____ Left eye: _____

Do you have any Drug allergies: YES / NO If yes, please list: _____

List any medication you take: (including oral contraceptives, aspirin, over the counter and home remedies)

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

	YES	NO	Relative		YES	NO	Relative
Blindness	_____	_____	_____	Heart Disease	_____	_____	_____
Cataract	_____	_____	_____	High Blood Pressure	_____	_____	_____
Crossed/Lazy Eye	_____	_____	_____	Kidney Disease	_____	_____	_____
Glaucoma	_____	_____	_____	Lupus	_____	_____	_____
Macular Degeneration	_____	_____	_____	Thyroid Disease	_____	_____	_____
Retinal Detachment	_____	_____	_____	Diabetes	_____	_____	_____
Retinal Disease	_____	_____	_____	Arthritis	_____	_____	_____
Other	_____	_____	_____	Cancer	_____	_____	_____

Social History

Do you drive: YES / NO If yes, do you have difficulty when driving: _____

Do you use tobacco products: YES / NO If yes, type / amount/ how long: _____

Do you drink alcohol: YES / NO If yes, type /amount / how long: _____

Do you use illegal drugs: YES / NO If yes, type /amount / how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	YES	NO
Constitutional		
Fever, Weight loss / gain	_____	_____
Integumentary (skin)	_____	_____
Neurological		
Headaches	_____	_____
Seizures	_____	_____
Migraines	_____	_____
Eyes		
Loss of vision	_____	_____
Blurred vision	_____	_____
Distorted vision / Halos	_____	_____
Double vision	_____	_____
Dryness	_____	_____
Mucous discharge	_____	_____
Redness	_____	_____
Sandy / Gritty feeling	_____	_____
Burning	_____	_____
Itching	_____	_____
Foreign body sensation	_____	_____
Excess tearing / Watering	_____	_____
Chronic infection of eye / lid	_____	_____
Glare / Light sensitivity	_____	_____
Stye / Chalazion	_____	_____
Flashes/Floaters	_____	_____
Eye Pain / Soreness	_____	_____
Tired Eyes	_____	_____
Glaucoma	_____	_____
Cataract	_____	_____
Crossed / Lazy Eye	_____	_____
Retinal detachment	_____	_____
Retinal disease	_____	_____
Macular degeneration	_____	_____
Blindness	_____	_____
Surgery / Injury	_____	_____

	YES	NO
Ears, Nose Mouth, Throat		
Allergies / Hay Fever	_____	_____
Sinus Congestion	_____	_____
Chronic Cough	_____	_____
Dry Throat / Mouth	_____	_____
Hard of Hearing	_____	_____
Respiratory		
Asthma	_____	_____
Chronic Bronchitis	_____	_____
Emphysema	_____	_____
Vascular / Cardiovascular		
Heart Pain	_____	_____
High Blood Pressure	_____	_____
Gastrointestinal		
Diarrhea	_____	_____
Constipation	_____	_____
Genitourinary		
Genitals / Kidney / Bladder	_____	_____
Bones / Joints / Muscles		
Rheumatoid Arthritis	_____	_____
Muscle Pain	_____	_____
Joint Pain	_____	_____
Lymphatic / Hematologic		
Bleeding	_____	_____
Cholesterol	_____	_____
Anemia	_____	_____
Allergic / Immunologic	_____	_____
Psychiatric		
Anxiety	_____	_____
Depression	_____	_____
Insomnia	_____	_____
Endocrine		
Diabetes	_____	_____
Thyroid, hypo / hyper	_____	_____

If you answered YES to any of the above or have a condition not listed, please explain: _____

In order to process your insurance claim, you must present your insurance card or voucher at the time of service. Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance. All returned checks are subject to a $30 service charge.

Please note that all sales are final, not subject to refunds or exchanges. Our goal is to provide excellent service, care, and quality. If you cannot adapt to your new eyewear from Frisco Family Vision, we must be notified and set up an appointment within 30 days from your dispensing or 6 weeks from your exam, whichever is shorter, at no charge. Lenses are custom made for you and the frame you chose and cannot be used for another frame. The patient may be responsible for any remake or difference in price for a remake. Frisco Family Vision is not responsible for eyewear obtained anywhere other than Frisco Family Vision.

_____ _____

Patient/Guardian Signature/Responsible Party Date

Doctor's Signature: _____ Date: _____